- ❑ Initiate Waiver services
- ❑ Service Modification
  - ☐ Add a service
  - ☐ Increasing hours of service
  - ☐ Decreasing hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

CSB _____

CSB provider #

_____

MR Waiver
Agency-Directed Companion Services
Individual Service Authorization Request

Provider Name _____ Provider Number _____

Name: _____ (Last, First MI) Start: _____ (Date) End: _____ (Date)

Medicaid Number: _____

SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS	OMR USE ONLY
Companion – S5135	_____ Hours / week x 52 = _____ Yearly total (1)	

Reason for the request: _____

Answer the questions and check the allowable activities included in the individual's plan. Indicate the *total* number of hours per day. Companion Services is limited to 8 hours per day.

Is there a therapeutic goal in the ISP as required? ☐ Yes ☐ No

Is the individual age 18 or older? ☐ Yes ☐ No

Assistance or support with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ tasks such as meal preparation, laundry, shopping							
☐ light housekeeping tasks							
☐ self-administration of medication							
☐ community access & recreational activities							
☐ assuring the safety of the individual							

Comments:

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) Signature Phone No. Fax No. Date